

Fulfilling First Nations health, cultural safety and equity accreditation standards in primary medical education: reflections from a First Nations desktop review team

Realising health equality for First Nations Peoples and Communities in Australia and New Zealand (Aotearoa) demands a shift in the way primary medical education providers conceptualise and enact equity, through their functions and programs. Following the release of the *Standards for assessment and accreditation of primary medical programs*¹ (2023) by the Australian Medical Council, a desktop review team, comprising First Nations medical education stakeholders from across Australia and Aotearoa, was formed by the Australian Medical Council. The team was tasked with evaluating preliminary self-assessments of primary medical education providers, regarding if and how they are currently positioned to meet the new standards pertaining to First Nations health, cultural safety and equity. In this perspective article, we offer our reflections on the desktop review process. Through sharing our reflections as First Nations Peoples, we aim to inform primary medical education providers and stakeholders of the challenges and benefits in a shared sovereignty approach, to realise meaningful progress in this space, and others.

Positionality statement

Most of the authors of this article, but not all, are members of the Australian Medical Council (AMC) Desktop Review Team (DRT) for primary medical programs (9 out of 12 members), as well as members of the AMC Indigenous Policy and Programs (IPP) team (AS, MJ, BG). We are a collective of Aboriginal and Torres Strait Islander Peoples from across Australia (the only Māori DRT member did not opt for authorship on this article), working daily in the medical education context: PS is a Biripi man, NM is a Wadawurrung/Wurundjeri woman, MM (Mackay) is a Wiradjuri woman, IL is a Larrakia/Karajarri man, MH-B is a Wiradjuri woman, MC is a Wonnarua/Kaapay Kuuyun/Yirrganydji/Meriam Mir/Kala woman, EM is a Gundungurra woman, MM (Muscat) is a Bidjara woman, KM is a Central Arrernte/Mara/Bunuba/Kija/Jaru woman, AS is a Wiradjuri man, MJ is a Pitjantjatjara woman and BG is a Dharug woman.

We represent often invisible, yet strong threads, entwined to hold many community relationships, medical schools and societies together. We are united in our efforts to realise a liberatory agenda, one that seeks to progress the medical education space for First Nations Peoples and Communities. Fundamentally, our objective is to amplify First Nations' conceptualisations, knowledges and voices within medical education, working to attain equality

for our peoples through centring equity. We represent great diversity in our cultures, perspectives and experiences; however, are united in our determination to be acknowledged and appreciated within the medical education academy.

We invite you to consider the potentials of social justice and epistemic pluralism within the medical education and health care environments, underpinned by cultural humility. We invite you to conceptualise a space where diverse knowledges, beliefs and realities are equally valid and valued, a space where ideological domination presents with it, limitations in realising equity, and thus equality. We invite you to demonstrate civil courage, to swim against the tide of Eurocentric superiority, to cast a critical lens over the realm of medical education, and to recognise the value in First Nations Peoples self-determining their medical care journey, supported by a culturally safe medical workforce.

Within this article, the term "First Nations Peoples" is used to refer to Aboriginal and Torres Strait Islander and Māori Peoples. The term "Indigenous" is also used when referenced by specific groups. A short glossary of key terms has been included (Box).

Glossary of key terms

Term	Definition
Epistemic pluralism	A recognition that multiple ways of knowing are equally valid and useful to consider, even when they conflict.
Equality	The same outcome is achieved for all involved.
Equity	The process required to realise equality, by recognising diversity in need, both individually and collectively.
Cultural humility	An ongoing process of self-reflection, self-reflexivity, and self-critique to appreciate relational positionality and enable mutually beneficial relationships.
Cultural safety	The creation of environments that are spiritually, socially, emotionally and physically safe for people, where there is no assault, challenge or denial of their identity, needs or cultural practices.
Self-determination	The right of people to make decisions about their lives, and encompasses the principles of choice, participation and control.
Shared sovereignty	A co-governance type model where power is shared equally between two or more parties for mutual benefit.

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Background

In 2023, after three years of comprehensive consultation, collaboration and development, the AMC released transformational accreditation standards for primary medical education providers in Australia and Aotearoa.¹ The new standards represent a significant contextual shift regarding what domains are valued in the contemporary medical profession. Notions of cultural safety, equity, self-determination, collaboration and the inclusion of First Nations knowledges and perspectives are palpable within the new standards. However, despite such focus, transforming medical schools to genuinely embed these concepts within their programs first requires a fundamental shift in institutional ideology.^{2,3} Medical education institutions that privilege Eurocentric, biomedical-informed practices are challenged to refocus and reconceptualise their role as socially responsible establishments that exercise their authority to promote epistemic pluralism, cultural safety and critical consciousness.^{4,5}

Perceived barriers to such transformation, often touted through narratives of capacity and resource limitations, institutional bureaucracy and ignorance, undermine the basic function of medical education. That is, as declared by the Medical Deans Australia and New Zealand, to “contribute to healthy communities through the development of high-quality, work-ready, adaptable, and patient-focused future doctors” (<https://medicaldeans.org.au/>). Such intent honours notions of professionalism, responsiveness and person-centredness, where the future medical workforce can provide care that is of high quality, regardless of a patient’s background, lived experience or intersecting identities.

Additionally, the Australian Commission for Safety and Quality in Health Care, the Australian Health Practitioner Regulation Agency (Ahpra), Te Tāhū Hauora Health Quality and Safety Commission, and Te Kaunihera Rata O Aotearoa Medical Council of New Zealand all promote health care that is culturally safe, of high quality and free from racism and discrimination.⁶⁻⁹ The progressive rhetoric evident throughout the directives of these peak authorities aligns intimately with, and is referenced in, the revised AMC standards, clarifying the responsibility of the modern medical professional to emphasise social, cultural and epistemic justice in health care.

The significance of self-determination for First Nations Peoples is discernibly centred throughout the structure and function of the AMC. This is evident across their business, which has allowed the organisation to establish a culturally safe and productive platform for First Nations Peoples and perspectives, to meaningfully contribute to equity and equality within medical education institutions and programs across Australia and Aotearoa. Such autonomy was extended to us, as the First Nations DRT, via the AMC IPP team, to enhance a culturally safe approach to reviewing the various medical school self-assessments against the revised standards, within the bounds of the AMC published procedures.

In sharing our experiences, including those of the AMC IPP team, it is hoped that other health and education institutions across Australia, Aotearoa, and indeed the world, enhance their understanding of a shared sovereignty approach with First Nations Peoples and Communities.

The CONSIDER reporting criteria checklist for health research involving Indigenous Peoples¹⁰ was completed for this article and can be found in [Supporting Information](#), part 1.

Gathering and exploring reflections

Following the desktop review process (detailed in [Supporting Information](#), part 2), we agreed that sharing our experiences may be of benefit to others, both from a DRT and an AMC IPP team perspective. A short anonymous survey was developed by the AMC IPP team ([Supporting Information](#), part 3) that DRT members could complete (6 members completed the survey). The survey sought to gain an understanding of the experiences of DRT members during the desktop review process, and explicitly stated that responses would inform a reflective peer-reviewed publication, as implied consent. In addition to the survey, PS developed a list of reflective questions ([Supporting Information](#), part 3) that DRT and AMC IPP team members could respond to, based on their experience during the process. The individuals that did respond are co-authors on this article. Both survey and reflective question responses underwent reflexive thematic analysis¹¹ by PS and were then verified by the co-authors.

Reflecting on reflections

As a group, we (DRT members) had a particularly positive experience working with the AMC during the desktop review and felt well supported, genuinely engaged, respected and valued, with a strong sense that our voices were able to lead conversations during the process. Many of us reported feeling culturally safe during the experience. Critical feedback included feeling overwhelmed and burdened by our involvement in the process, confusion surrounding the review for those new to AMC processes, assumptions and ignorance demonstrated by medical schools, limited communication to medical schools by the AMC, and a lack of review training provided by the AMC. Four intersecting themes were generated via reflexive analysis of our reflections: First Nations-led and self-determination; capacity and confidence building; collaboration and collectivism; and cultural safety.

First Nations-led and self-determination

The importance of “First Nations-led” and “self-determination” as guiding concepts for schools cannot be overstated. These are not merely aspirational concepts, but essential principles that must be embedded throughout the medical education system, institutions and within programs. The axiom “Nothing about us without us” holds immense value for schools looking to meaningfully advance in First Nations health, cultural safety and equity standards.

“First Nations-led” and “self-determination” mean that we, as First Nations Peoples, determine priorities and lead in every step of the decision-making process, without external pressure or influence (besides from First Nations Peoples and Communities), and are not an afterthought used as a tick-box exercise. It means we are supported by the school in our right to lead and make decisions that impact us and our communities, guided and informed by the First Nations Communities that we serve and are connected to in our personal and professional roles. It means that with leadership comes responsibility, to the school and students, to other First Nations Peoples, and to our Communities. It means that schools must recognise that we are the experts in how our cultural values, knowledges, traditions and practices should be meaningfully integrated into medical programs, to ensure students gain an appreciation for the significance of diverse First Nations perspectives in informing their medical practice. Therefore, schools need to recognise the significance of us leading the sharing and integration of our cultural knowledges to bolster school re-/accreditation and student development. It also means that one voice should not be privileged, but rather all First Nations voices are equally valid and regarded within the school, consistent with values of inclusivity, respect and collectivism.

The potential for schools to experience discomfort with the application of these concepts is both expected and necessary to realise positive transformation in this space. A significant contributor to this discomfort relates to truth-telling, about our colonial past, about our contemporary experiences as First Nations Peoples, and about our collective reluctance, as colonised nations, to address the ongoing injustices imposed on First Nations Peoples. The prospect of First Nations control over relevant aspects of medical programs means that we decide if the school and its program/s are culturally safe, we decide if First Nations health, cultural safety and equity (in collaboration with other equity groups) standards are met, and we invite non-First Nations staff to our table on our terms, to progress our agenda, for the benefit of the school, its program/s, the student cohort, and First Nations Communities.

Capacity and confidence building

Capacity building through involvement in the desktop review process was tied primarily to confidence, with increased levels of confidence related to the new standards and the AMC review process reported. Such confidence was developed through, and regarding, a greater understanding of the new standards to inform future strategic and educational approaches and directions, as well as challenging existing dominant systems, knowledges and practices within medical education. A significant feature of this increased confidence relates to our enhanced capacity to advocate for change within our affiliated institutions. Development of leadership skills and characteristics was promoted through involvement. Importantly, the review process contributed to meaningful validation of our positions as sovereign

First Nations People within the medical education space. Such validation has fostered a greater sense of courage to collaboratively transform the medical education space through realising equity and self-determination.

Although involvement added to an already excessive workload for many of us, it was seen as a worthwhile and rewarding opportunity that provided a sense of purpose and fulfillment to make a meaningful impact in this space. This was primarily attributed to a centring of First Nations voices throughout the process. The comprehensive support provided by the AMC helped to ease some of the burden associated with involvement, with robust cultural support a significant factor. Some of us reported feeling threatened due to participating in a system that is informed and dictated by Western ways of working, with defensiveness and caution in full participation an outcome in some cases.

Many of us also expressed our confidence in providing critical feedback to the AMC on applied processes and systems. This was justified through the creation of a safe space by the AMC IPP team for DRT members to be authentic and honest without fear of retribution.

Collaboration and collectivism

Our reflections focused on the need for institutions to centre, value, support and meaningfully engage with diverse First Nations Peoples and perspectives, while attending to critical reflection and reflexivity to enhance cultural humility. Other reflections included the need for medical schools to establish and adequately support ongoing inter- and cross-institutional collaborative capacity building spaces for First Nations medical educators. We recommend the creation of safe, collaborative spaces for First Nations People to share cultural knowledges and wisdom with non-First Nations faculty, to ensure First Nations perspectives are meaningfully integrated within and across medical programs. To appreciate the structural barriers to First Nations collaboration, and thus school advancement in meeting the new standards, we also recognise that a critical consciousness is needed in non-First Nations staff and institutions.

The notion of inter- and cross-institutional collaboration and dialogue, to share knowledges, learnings, resources, frameworks and strategies, aligns with First Nations ways of working (ie, for the greater good of the community, rather than individual success — reciprocity and accountability). Through cross-institutional collaboration, greater support in ensuring all schools meet the standards related to First Nations health, cultural safety and equity can be realised. A move away from individual school advancement and competition, aligned with Eurocentric concepts of possession and ownership, to a collective approach is emphasised. To enable this, schools must acknowledge and celebrate cultural diversity and collectivism, reflected through their structure, systems and processes.

We propose that First Nations collaboration within and across schools will bring together a diversity of knowledges, perspectives, experiences and skills

that can inform a contemporary curriculum and pedagogical framework for schools to contextually implement across Australia and Aotearoa. We recommend this collective, community-grounded, wisdom development approach to amplify First Nations voices and agency within the primary medical education system. Cross-institutional First Nations collaboration can leverage pre-existing relationships and trust to support joint research initiatives and provide an increased feeling of safety for First Nations staff and students.

Beyond the medical school context, creating space for collaboration with the AMC and other First Nations educators is seen as critical to realise progress in meeting and exceeding the standards. This enables a shared learning of knowledges and approaches, and allows First Nations Peoples to leverage the influence of the AMC to facilitate advocacy and progress within schools and program/s. We stress the importance of such collaboration for perspective validation, cultural safety, burden relief and providing a sense of connectedness, belonging and purpose within the medical education space.

Cultural safety

Overall, we felt culturally safe during our involvement in the review process. Strategies such as the creation of a physically and culturally safe “First Nations breakout room” during in-person meetings was seen as a positive initiative. We (DRT members) felt that our knowledges and perspectives were valued during AMC engagements and were able to discuss matters without feeling shame. Many of us identified the AMC approach to the review process as a model for other institutions, including medical schools, to learn from and adopt, with comments relating to the centring of First Nations perspectives, supported by a dedicated AMC IPP team. Our reflections identified the importance of an ongoing commitment to cultural safety, highlighting that although the AMC is relatively well placed regarding such commitment, there must be a constant awareness of *becoming* rather than *being* culturally safe. Despite such positive feedback, a small proportion of us (DRT members) felt culturally unsafe in certain engagements during the review process, demonstrating the fragility and complexity of cultural safety — one’s experience of cultural safety is unique and heterogenous.

The impact of the AMC commitment to cultural safety was evident through the First Nations-led development and implementation of the new standards, which centre First Nations perspectives and needs. Moreover, this extended to the desktop review process, with the First Nations DRT established and provided with significant agency during the process. Many of us felt that such commitment was palpable through the intentional safe spaces that the AMC IPP team created for yarning and their responsiveness to act on DRT member feedback. There was a sense among the DRT members that while there is still much work to be done, the AMC approach reflects a genuine

commitment and solid foundation for progress, one that is action-oriented and prioritises First Nations voices in medical education. Critically, the AMC’s continued commitment to First Nations health and Peoples was broached, questioning how support for the needs of First Nations Peoples will be fulfilled if, and when, conflicting needs of medical schools and non-First Nations colleagues arise.

Discussion and conclusion

The collaborative approach adopted by the AMC regarding the review of primary medical education provider self-assessments against the revised accreditation standards demonstrates the significance, effectiveness and efficiency of shared sovereignty with First Nations Peoples. The reflections represent a focused, insightful and unified voice that echoes First Nations Community’s calls for equity, equality, self-determination and a centring of First Nations perspectives within health and medical contexts.¹² Despite this, a lack of Māori representation in the authorship is a glaring limitation of this article, with only one Māori person involved in the DRT. The merit in a First Nations sovereign approach, where leadership and decision-making lie exclusively with First Nations Peoples, cannot be overstated, and is reflective of a broader First Nations collective self-determination agenda.¹³

Non-First Nations governed institutions, such as medical schools, health care services, and accreditation institutions have an ethical responsibility to ensure meaningful, ongoing collaboration with First Nations Peoples that centre self-determination and cultural safety.¹⁴ This responsibility extends to ongoing critical self-reflection and reflexive practice when working with First Nations People, ensuring accountability.¹⁵

To advance First Nations equity within medical schools and programs, collectively critiquing Eurocentric discourses and practices that dominate medical education, and health care more broadly, is encouraged.² Primary medical education providers and stakeholders must be critically conscious of the limitations in these power-laden epistemes and consider how epistemic pluralism expands knowledge potential for all.⁴ Valuing and validating diverse health perspectives enables genuine inclusivity in health care for First Nations Peoples, promoting equity in health care access and equality in health care outcomes.¹⁶

It is important for primary medical education providers and accreditors to recognise that we, as First Nations Peoples, are stewards of our Communities, positioned with privilege within the academy to fulfil a goal of improved health care and outcomes for our People. It is through us that the voices of First Nations Peoples and Communities are centred, propagated and amplified within the medical education space. This mandate requires meaningful establishment and support of culturally safe spaces by primary medical education providers, where self-determination, collaboration and capacity building can realise this objective. Moreover, our diverse knowledges and experiences offer great

potential to transform medical education, re-centring humanitarianism in medicine.

The benefits in open, shared learning between First Nations and non-First Nations Peoples cannot be overstated. This extends well beyond the medical education space, or even the broader education and health space, into such spheres as business, politics and environmental management.¹⁷ A shared sovereignty framework and approach to working can enable a plethora of perspectives and methods to collide, interact and transform, to produce novel understandings that offer mutual benefit potential (as was evident during the desktop review).

Despite an identified need to address fundamental priority areas, such as cultural safety, medical schools can realise tangible progress in meeting and exceeding the new standards through a genuine commitment to shared sovereignty, centring principles of “First Nations-led” and “self-determination”. The AMC approach to the desktop review is an imperfect model that other institutions, including medical schools, could learn from and adopt within their local context. Ultimately, a shared sovereignty approach values First Nations perspectives and knowledges, which can enhance cultural safety, equity, agency, self-determination and student cultural capability development, and thus school advancement to meet and exceed First Nations health, cultural safety and equity standards.

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Supporting Information

Additional Supporting Information is included with the online version of this article.